

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove capstan papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04465
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOUIS MARCELLUS BIVINS		4. DATE OF DEATH Month APRIL Day 4 Year 1962	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 16, 1888
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAIL KEEPER		10b. KIND OF BUSINESS OR INDUSTRY COUNTY JAIL	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME RICHARD BIVINS		14. MOTHER'S MAIDEN NAME MARTHA HEMSLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-16-3088	
17. INFORMANT AGNES F. BIVINS, LA PLATA, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 hours DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-4 19 62 to 4-4 19 62 that (I) (we) last saw the deceased alive on 4-4 19 62 and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE F.M. JOHNSON M.D.		22b. DATE SIGNED 4-4-62	
22c. PHYSICIAN'S NAME (Type) F.M. JOHNSON M.D.		22d. ADDRESS LA PLATA, MD.	
23a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-7-62	
23c. NAME OF CEMETERY OR CREMATORY SACRED HEART		23d. LOCATION (City, town, or county) (State) LA PLATA, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE The HUNTT FUNERAL HOME, WILMINGTON, MD.		25a. REC'D BY REGISTRAR APR 10 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

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CENTRE OF LEAD

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CHIEF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate should be filed with the funeral director, and in any event, within 72 hours after death. After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04466

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b La Plata	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		e. STREET ADDRESS Prospect Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MITCHELL Middle CLARK Last COCHRANE		4. DATE OF DEATH Month April Day 1 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 5, 1900
9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Howard Drug, Co.	
11. BIRTHPLACE (State or foreign country) La Plata, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Mitchell Cochrane		14. MOTHER'S MAIDEN NAME Rebecca Rice	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-09-7978	
17. INFORMANT Mrs. Loretta Cochrane - (Wife) - La Plata, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SECONDARY POLYCYTHEMIA, SEVERE > 1 YR. (c) EMPHYSEMA > 1 YR. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE CARDIO PULMONARY FAILURE			
INTERVAL BETWEEN ONSET AND DEATH 12 HRS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN 1962 to APR 1 1962 that (I) (not) last saw the deceased alive on APR 1 1962 and that death occurred at 2A M, from the causes and on the date stated above.			
22a. SIGNATURE Robert W. Merkle		22b. DATE SIGNED APR 1 1962	
22c. PHYSICIAN'S NAME (Type) Robert W. Merkle, M.D.		22d. ADDRESS La Plata, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/3/1962	
23c. NAME OF CEMETERY OR CREMATORY Mt. Rest Cemetery		23d. LOCATION (City, town, or county) (State) La Plata, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc.		25a. REC'D BY REGISTRAR APR 3 1962	
25b. REGISTRAR'S SIGNATURE Arthur S. Thoms			

0436

CERTIFICATE OF DEATH

1155

(M)

DECEASED

LAST NAME

MR. JAMES

DATE OF BIRTH

PLACE OF BIRTH

CITY OF BIRTH

STATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF CLERK

CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04467

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEWPORT-RURAL		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RACHAEL ANN DORSEY		4. DATE OF DEATH Month Day Year Apr 7 1962	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? 1874
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HENRY DORSEY	
14. MOTHER'S MAIDEN NAME MARGARET MIDDLETON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address JOSEPH DORSEY, Hughesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 to Apr 7, 1962 that (I) (we) last saw the deceased alive on Feb 19 1962 and that death occurred at 7 M, from the causes and on the date stated above.			
22a. SIGNATURE F. M. JOHNSON M.D.		22b. DATE SIGNED 4-7-62	
22c. PHYSICIAN'S NAME (Type) F. M. JOHNSON		22d. ADDRESS La Plata, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-9-62	
23c. NAME OF CEMETERY OR CREMATORY ST MARYS		23d. LOCATION (City, town, or county) (State) NEWPORT, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, MD.		25a. REC'D BY REGISTRAR DATE APR 10 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04471 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04469

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Henrico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Richmond	
c. LENGTH OF STAY IN Ib D.O.A.		d. STREET ADDRESS 2306 Brockway Lane	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physicians Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gertrude First Middle Last		4. DATE OF DEATH April 3 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-26-1916
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Clifford La Foy	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Frank Greene (Husband)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Depressed Skull Fracture Left Temporal Area DUE TO (b) Crushed Chest DUE TO (c) Auto Accident Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 20 min. 20 min. 20 min.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto which pulled into path of a truck		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 4-3 19 62	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
20f. (City or town) Newburg		(County) Charles (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Merkle		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Merkle, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4/4/1962	
22c. NAME OF CEMETERY OR CREMATORY Woody Funeral Home		22d. LOCATION (City, town, or country) Richmond, Virginia	
23. FUNERAL DIRECTOR Archart Funeral Home, Inc. La Plata, Md.		24a. REC'D BY REGISTRAR DATE APR 9 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris		DATE SIGNED 4-4-1962	

MEDICAL CERTIFICATION

MASTHEAD OF THE NEW YORK TIMES
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Deceased

Residence

LA PLATA

Physician's Special Remarks

LA PLATA

AT HOME

AT HOME

Officer's Name

Home

Home

John A. Miller

County Funeral Home

Funeral Home, Inc. LA PLATA, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
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FOR STATE
HEALTH DEPT.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Braintree</u> c. LENGTH OF STAY IN 1b <u>12 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chapman Hosp. & Infirmary</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MASS</u> b. COUNTY <u>Norfolk</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Braintree</u> d. STREET ADDRESS <u>15 Ardmore St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>CHARLES ARTHUR HALE</u>				4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1962</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-28-92</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Draftsman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Beck Steel</u>				11. BIRTHPLACE (State or foreign country) <u>Henderson Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur Hale</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>024038086</u>				17. INFORMANT Address <u>Oliver Helen Braintree Mass.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4-20-1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-7-62</u> ACTUAL SIGNATURE <u>E. J. EDELIN</u> M.D. EXAMINER'S NAME (Type) <u>E. J. EDELIN</u> Address (Street, city, town, or county) 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>4/11/1962</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Blue Hill Cemetery</u> 22d. LOCATION (City, town, or country) (State) <u>Braintree, Massachusetts</u> 23. FUNERAL DIRECTOR <u>Archart Funeral Home, Inc.</u> ADDRESS <u>-La Plata, Md.</u> 24a. REC'D BY REGISTRAR <u>APR 18 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Wm. S. F. ...</u>											

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RECEIVED BY THE MEDICAL DEPARTMENT
MEDICAL DEPARTMENT, ARMY AIR FORCE

1942

RECEIVED

RECEIVED

Chlorine

Chlorine gas is a colorless gas with a strong odor of bleach. It is highly toxic and can cause severe respiratory distress and death. It is used in chemical warfare and as a disinfectant.

Chlorine gas is a colorless gas with a strong odor of bleach. It is highly toxic and can cause severe respiratory distress and death. It is used in chemical warfare and as a disinfectant.

Chlorine gas is a colorless gas with a strong odor of bleach. It is highly toxic and can cause severe respiratory distress and death. It is used in chemical warfare and as a disinfectant.

1942/1943 1944/1945 1946/1947 1948/1949 1950/1951 1952/1953 1954/1955 1956/1957 1958/1959 1960/1961 1962/1963 1964/1965 1966/1967 1968/1969 1970/1971 1972/1973 1974/1975 1976/1977 1978/1979 1980/1981 1982/1983 1984/1985 1986/1987 1988/1989 1990/1991 1992/1993 1994/1995 1996/1997 1998/1999 2000/2001 2002/2003 2004/2005 2006/2007 2008/2009 2010/2011 2012/2013 2014/2015 2016/2017 2018/2019 2020/2021 2022/2023 2024/2025

AT (H) (M) (N) (O) (P) (Q) (R) (S) (T) (U) (V) (W) (X) (Y) (Z) (AA) (AB) (AC) (AD) (AE) (AF) (AG) (AH) (AI) (AJ) (AK) (AL) (AM) (AN) (AO) (AP) (AQ) (AR) (AS) (AT) (AU) (AV) (AW) (AX) (AY) (AZ) (BA) (BB) (BC) (BD) (BE) (BF) (BG) (BH) (BI) (BJ) (BK) (BL) (BM) (BN) (BO) (BP) (BQ) (BR) (BS) (BT) (BU) (BV) (BW) (BX) (BY) (BZ) (CA) (CB) (CC) (CD) (CE) (CF) (CG) (CH) (CI) (CJ) (CK) (CL) (CM) (CN) (CO) (CP) (CQ) (CR) (CS) (CT) (CU) (CV) (CW) (CX) (CY) (CZ) (DA) (DB) (DC) (DD) (DE) (DF) (DG) (DH) (DI) (DJ) (DK) (DL) (DM) (DN) (DO) (DP) (DQ) (DR) (DS) (DT) (DU) (DV) (DW) (DX) (DY) (DZ) (EA) (EB) (EC) (ED) (EE) (EF) (EG) (EH) (EI) (EJ) (EK) (EL) (EM) (EN) (EO) (EP) (EQ) (ER) (ES) (ET) (EU) (EV) (EW) (EX) (EY) (EZ) (FA) (FB) (FC) (FD) (FE) (FF) (FG) (FH) (FI) (FJ) (FK) (FL) (FM) (FN) (FO) (FP) (FQ) (FR) (FS) (FT) (FU) (FV) (FW) (FX) (FY) (FZ) (GA) (GB) (GC) (GD) (GE) (GF) (GG) (GH) (GI) (GJ) (GK) (GL) (GM) (GN) (GO) (GP) (GQ) (GR) (GS) (GT) (GU) (GV) (GW) (GX) (GY) (GZ) (HA) (HB) (HC) (HD) (HE) (HF) (HG) (HH) (HI) (HJ) (HK) (HL) (HM) (HN) (HO) (HP) (HQ) (HR) (HS) (HT) (HU) (HV) (HW) (HX) (HY) (HZ) (IA) (IB) (IC) (ID) (IE) (IF) (IG) (IH) (II) (IJ) (IK) (IL) (IM) (IN) (IO) (IP) (IQ) (IR) (IS) (IT) (IU) (IV) (IW) (IX) (IY) (IZ) (JA) (JB) (JC) (JD) (JE) (JF) (JG) (JH) (JI) (JJ) (JK) (JL) (JM) (JN) (JO) (JP) (JQ) (JR) (JS) (JT) (JU) (JV) (JW) (JX) (JY) (JZ) (KA) (KB) (KC) (KD) (KE) (KF) (KG) (KH) (KI) (KJ) (KK) (KL) (KM) (KN) (KO) (KP) (KQ) (KR) (KS) (KT) (KU) (KV) (KW) (KX) (KY) (KZ) (LA) (LB) (LC) (LD) (LE) (LF) (LG) (LH) (LI) (LJ) (LK) (LL) (LM) (LN) (LO) (LP) (LQ) (LR) (LS) (LT) (LU) (LV) (LW) (LX) (LY) (LZ) (MA) (MB) (MC) (MD) (ME) (MF) (MG) (MH) (MI) (MJ) (MK) (ML) (MM) (MN) (MO) (MP) (MQ) (MR) (MS) (MT) (MU) (MV) (MW) (MX) (MY) (MZ) (NA) (NB) (NC) (ND) (NE) (NF) (NG) (NH) (NI) (NJ) (NK) (NL) (NM) (NN) (NO) (NP) (NQ) (NR) (NS) (NT) (NU) (NV) (NW) (NX) (NY) (NZ) (OA) (OB) (OC) (OD) (OE) (OF) (OG) (OH) (OI) (OJ) (OK) (OL) (OM) (ON) (OO) (OP) (OQ) (OR) (OS) (OT) (OU) (OV) (OW) (OX) (OY) (OZ) (PA) (PB) (PC) (PD) (PE) (PF) (PG) (PH) (PI) (PJ) (PK) (PL) (PM) (PN) (PO) (PP) (PQ) (PR) (PS) (PT) (PU) (PV) (PW) (PX) (PY) (PZ) (QA) (QB) (QC) (QD) (QE) (QF) (QG) (QH) (QI) (QJ) (QK) (QL) (QM) (QN) (QO) (QP) (QQ) (QR) (QS) (QT) (QU) (QV) (QW) (QX) (QY) (QZ) (RA) (RB) (RC) (RD) (RE) (RF) (RG) (RH) (RI) (RJ) (RK) (RL) (RM) (RN) (RO) (RP) (RQ) (RR) (RS) (RT) (RU) (RV) (RW) (RX) (RY) (RZ) (SA) (SB) (SC) (SD) (SE) (SF) (SG) (SH) (SI) (SJ) (SK) (SL) (SM) (SN) (SO) (SP) (SQ) (SR) (SS) (ST) (SU) (SV) (SW) (SX) (SY) (SZ) (TA) (TB) (TC) (TD) (TE) (TF) (TG) (TH) (TI) (TJ) (TK) (TL) (TM) (TN) (TO) (TP) (TQ) (TR) (TS) (TT) (TU) (TV) (TW) (TX) (TY) (TZ) (UA) (UB) (UC) (UD) (UE) (UF) (UG) (UH) (UI) (UJ) (UK) (UL) (UM) (UN) (UO) (UP) (UQ) (UR) (US) (UT) (UU) (UV) (UW) (UX) (UY) (UZ) (VA) (VB) (VC) (VD) (VE) (VF) (VG) (VH) (VI) (VJ) (VK) (VL) (VM) (VN) (VO) (VP) (VQ) (VR) (VS) (VT) (VU) (VV) (VW) (VX) (VY) (VZ) (WA) (WB) (WC) (WD) (WE) (WF) (WG) (WH) (WI) (WJ) (WK) (WL) (WM) (WN) (WO) (WP) (WQ) (WR) (WS) (WT) (WU) (WV) (WW) (WX) (WY) (WZ) (XA) (XB) (XC) (XD) (XE) (XF) (XG) (XH) (XI) (XJ) (XK) (XL) (XM) (XN) (XO) (XP) (XQ) (XR) (XS) (XT) (XU) (XV) (XW) (XX) (XY) (XZ) (YA) (YB) (YC) (YD) (YE) (YF) (YG) (YH) (YI) (YJ) (YK) (YL) (YM) (YN) (YO) (YP) (YQ) (YR) (YS) (YT) (YU) (YV) (YW) (YX) (YZ) (ZA) (ZB) (ZC) (ZD) (ZE) (ZF) (ZG) (ZH) (ZI) (ZJ) (ZK) (ZL) (ZM) (ZN) (ZO) (ZP) (ZQ) (ZR) (ZS) (ZT) (ZU) (ZV) (ZW) (ZX) (ZY) (ZZ)

1
FOR STATE
HEALTH DEPT.

Items 18-21 Film 313 522623 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04473 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04471

1. PLACE OF DEATH a. COUNTY Charles MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Charles		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) La Plata			c. LENGTH OF STAY in 1b D.O.A.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Phys. Memorial Hospital D.O.A.			e. STREET ADDRESS Marshall Hall		
3. NAME OF DECEASED (Type or print) First DORIS Middle Lorraine Last HALEY			4. DATE OF DEATH Month April Day 29 Year 1962		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1921	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) Indian Head, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Judson Pullian			14. MOTHER'S MAIDEN NAME May Hoover		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578 -18-4536	17. INFORMANT Mr. Edward L/. Haley -Husband- Marshall Hall		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate intoxication 871.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute alcoholism					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Ingestion of overdosage of barbiturates			
20c. TIME OF INJURY Month, Day, Year Hour XXXX p.m. 4/28 1962	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House- Home	20f. (City or town) Marshall Hall	(County) Md.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE Peter W. Rieckert		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/30/62	
EXAMINER'S NAME (Type) Peter W. Rieckert, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/2/1962	22c. NAME OF CEMETERY OR CREMATORY Bumpy Oak Cemetery		22d. LOCATION (City, town, or country) Pomonkey, Maryland
23. FUNERAL DIRECTOR Archart Funeral Home, Inc.		ADDRESS Archart Funeral Home, Inc. -La Plata, Md.		24a. REC'D BY REGISTRAR MAY 3 '62	24b. REGISTRAR'S SIGNATURE Arthur S. Thorne

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the delay should be noted in the space provided. The certificate should be executed in duplicate, one copy to be retained by the Medical Examiner's Office and the other to be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the funeral director, and the funeral director, after this certificate has been signed by the attending physician and completely filled, should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

BP

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
04474						04472					
1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CHARLES					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BRYANTOWN					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHYSICIANS MEMORIAL						d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last F. DESALES HARPER						4. DATE OF DEATH Month Day Year APRIL 13 1962					
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 17, 1885		9. AGE (In years lost birthday) yrs. 77		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Harper						14. MOTHER'S MAIDEN NAME Rebecca Makle					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address HELEN HARPER, BRYANTOWN, MARYLAND					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Posterior Coronary Infarction DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 day DUE TO 10 years (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4-12 19 62 to 4-13 19 62 that (I) (we) last saw the deceased alive on 4-13 19 62 , and that death occurred at 2A M, from the causes and on the date stated above.											
22a. SIGNATURE F. M. Johnson				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-13-62					
22c. PHYSICIAN'S NAME (Type) F. M. JOHNSON M.D.				22d. ADDRESS LAPLATA MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-16-62		23c. NAME OF CEMETERY OR CREMATORY ST MARYS				23d. LOCATION (City, town, or county) (State) BRYANTOWN, MARYLAND			
24. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, MD.						ADDRESS		25a. REC'D BY REGISTRAR DATE APR 17 1962		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04778

STATE OF TEXAS

04778

Thomas Harper
placed in the
hospital

Eastern University
of Texas

W. Johnson

1
FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Director. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/6D

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
04473 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04473										
Items 18 & 21, Film G-312 5/17/62.cac										
1. PLACE OF DEATH a. COUNTY Charles MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Charles					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Patuxent City					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Patuxent City					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS Patuxent City					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First BESSIE Middle LOCKS Last LOCKS					4. DATE OF DEATH Month April Day 15 Year 19 62					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 47 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					11. BIRTHPLACE (State or foreign country) Rosehill N.C.					12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Robert Ennis					14. MOTHER'S MAIDEN NAME Catherine Jane					Address
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT James Mainer			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute alcoholism 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Russell S. Fisher					CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 4/16/62
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 4-26-62		22c. NAME OF CEMETERY OR CREMATORY Rosehill Cem		22d. LOCATION (City, town, or country) (State) Rosehill N.C.	
23. FUNERAL DIRECTOR Clay O Wilson					ADDRESS 1000		24a. REC'D BY REGISTRAR APR 21 1962		24b. REGISTRAR'S SIGNATURE Arthur L. House	

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TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04476
04474
04474

1. PLACE OF DEATH a. COUNTY CHARLES COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARBURY c. LENGTH OF STAY in 1b 4 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RFD 1 MARBURY				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY CHAS. CO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARBURY d. STREET ADDRESS RFD 1 MARBURY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARTHA BIRD MILLS		4. DATE OF DEATH 4 25 1962		5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 2, 1882 9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) KING GEORGE, VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT GARNER		14. MOTHER'S MAIDEN NAME JANE SCOTT		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO. 16. SOCIAL SECURITY NO. NONE. 17. INFORMANT MARY MAGDALENE SOUTHERLAND Address MARBURY, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VASCULAR ACCIDENT 331X DUE TO HYPERTENSIVE DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO OLD AGE, ARTERIOSCLEROSIS (b) YEARS (c) YEARS				INTERVAL BETWEEN ONSET AND DEATH 1 MINUTE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FLU WITH PNEUMONIA FEB 1962				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from FEB 19 62 to 4/25 19 62 , that (I) (see) last saw the deceased alive on Mar 10 19 62 and that death occurred at 6 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Robert W. Merkley M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/25/62	
22c. PHYSICIAN'S NAME (Type) ROBT. W. MERKLEY				22d. ADDRESS LA PLATA, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/27/1962		23c. NAME OF CEMETERY OR CREMATORY Chicamuxen Methodist		23d. LOCATION (City, town or county) (State) Chicamuxen, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Arbait Funeral Home, Inc ADDRESS La Plata				25a. REC'D BY REGISTRAR MAY 3 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

INDEX

1955

(M)

JANE

ROBERT

NOTE

NO

Robert 1/23/55
JANE 1/23/55

04477

CERTIFICATE OF DEATH

Reg. Dist. No. 04475

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>				c. LENGTH OF STAY IN 1b <u>2-Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>211 Holden Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Francis Murphy</u>				4. DATE OF DEATH Month Day Year <u>4-4-62</u> 19 <u>62</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W-US</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-1-23</u>		9. AGE (In years last birthday) yrs. <u>38</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Norfolk, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>James Francis Murphy</u>			
14. MOTHER'S MAIDEN NAME <u>Marion Veronica Titmuss</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>229-14-9918</u>				17. INFORMANT Address <u>Wife-Mrs J.F. Murphy 211-Holden Road Indian Head Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>62</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>3-29-62</u> , 19 <u>62</u> , to <u>4-4-62</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>4-4-62</u> , 19 <u>62</u> , and that death occurred at <u>10-30P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>James E. Andrews MD</u>				M.D. <u>17 Potomac Ave Indian Head Md. 4-4-62</u>			
PHYSICIAN'S NAME (Type) <u>James E. Andrews MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/7/1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Norfolk, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home, Inc. - La Plata, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 9 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. It should be filed with the funeral director. The funeral director should be notified by the funeral director, and the certificate should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the funeral director or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 4
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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04478
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04476

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHYSICIANS MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RONALD LEE PICKERAL		4. DATE OF DEATH Month Day Year APRIL 3 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 31 1962
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CURTIS PICKERAL		14. MOTHER'S MAIDEN NAME NANCY ANN MCKINSEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT CURTIS PICKERAL, BRYANTOWN, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) incomplete alveolar expansion 774X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) prematurity DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I (a) congenital malformation of the mandible & maxilla		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3:31 1962 to 4-3 1962, that (I) (we) last saw the deceased alive on 4-2 1962, and that death occurred at 4:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE F. M. JOHNSON		22b. DATE SIGNED 4-3-62	
22c. PHYSICIAN'S NAME (Type) F. M. JOHNSON M.D.		22d. ADDRESS LA PLATA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-5-62	
23c. NAME OF CEMETERY OR CREMATORY ST MARYS		23d. LOCATION (City, town, or county) (State) BRYANTOWN, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, W. 1601, Md.		25a. REC'D BY REGISTRAR APR 6 '62 DATE	
25b. REGISTRAR'S SIGNATURE Anthony S. France			

2-001604

14326

CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04479											
04477											
1. PLACE OF DEATH a. COUNTY CHARLES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HUGHESVILLE-RURAL c. LENGTH OF STAY IN b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X HUGHESVILLE-RURAL d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle THOMAS Last _____						4. DATE OF DEATH Month APRIL Day 9 Year 1962					
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 5, 1880		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY FARMING				11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN THOMAS SR.						14. MOTHER'S MAIDEN NAME UNKNOWN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT ESTELLE THOMAS, HUGHESVILLE, MD. Address _____					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL - VASCULAR ACCID. 331X DUE TO ARTERIOSCLEROSIS OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO OLD AGE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS UNK. "											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. _____ p.m. _____		Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) _____											
ACTUAL SIGNATURE R. W. Muddle				M.D. _____				DATE SIGNED 4/10/62			
EXAMINER'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-12-62		22c. NAME OF CEMETERY OR CREMATORY ST MARYS				22d. LOCATION (City, town, or county) (State) BRYANTOWN, MARYLAND			
23. FUNERAL DIRECTOR The HUNT FUNERAL HOME, WALDORF, MD. ADDRESS _____						24a. REC'D BY REGISTRAR APR 13 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

04173

INTERNAL EXAMINER'S CERTIFICATE OF RESULTS

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04480										04478																								
1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES																								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HUGHESVILLE										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HUGHESVILLE																								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																								
3. NAME OF DECEASED (Type or print) First REBECCA Middle WILLIAMS Last WILLIAMS										4. DATE OF DEATH Month APRIL Day 19 Year 1962																								
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 19, 1961				9. AGE (In years lost birthday) yrs. 4		IF UNDER 1 YEAR Month 4 Days 4		IF UNDER 24 HRS. Hours 4 Min. 4																				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE					10b. KIND OF BUSINESS OR INDUSTRY NONE					11. BIRTHPLACE (State or foreign country) MARYLAND					12. CITIZEN OF WHAT COUNTRY? U.S.A.																			
13. FATHER'S NAME JAMES LEE TAFT										14. MOTHER'S MAIDEN NAME MARY K. SEWELL																								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. NONE					17. INFORMANT Address MARY K. WILLIAMS, HUGHESVILLE, MD.																								
MEDICAL CERTIFICATION															18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tracheo Bronchitis (acute) 500X DUE TO acute chest cold Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) acute upper respiratory cold DUE TO acute upper respiratory cold (c) acute upper respiratory cold															INTERVAL BETWEEN ONSET AND DEATH 1 day 4 day 4 day				
															PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
															20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
															20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19					20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Mar 18, 1962 to April 19, 1962 that (I) (we) last saw the deceased alive on April 18, 1962 and that death occurred at 4 A. M, from the causes and on the date stated above.																																		
22a. SIGNATURE Vahel M. Seron										M.D. X ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 4/19/62																			
22c. PHYSICIAN'S NAME (Type) VAAHEL M. SERON MD										22d. ADDRESS AQUASCO, MD.																								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF 4-19-62					23c. NAME OF CEMETERY OR CREMATORY ST MARYS					23d. LOCATION (City, town, or county) (State) BRYANTOWN, MD.																			
24. FUNERAL DIRECTOR'S SIGNATURE Robert Funeral Home, Baltimore, Md.															ADDRESS					25a. REC'D BY REGISTRAR DATE APR 23 '62					25b. REGISTRAR'S SIGNATURE Wm. E. Hume									

1-020518

U4158

CONTINUATION OF DEATH

01420



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
04481														
CERTIFICATE OF DEATH														
Reg. Dist. No. 04479														
1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Aquasco</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Aquasco</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____					d. STREET ADDRESS <u>Rural</u>									
					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM HENRY YOUNG</u>					4. DATE OF DEATH Month Day Year <u>April 17 1962</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 14, 1881</u>		9. AGE (In years last birthday) <u>81</u> yrs.						
						IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>						
13. FATHER'S NAME <u>John W. Young</u>					14. MOTHER'S MAIDEN NAME <u>Mary Ann Trueeman</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO. <u>214-36-1846</u>					17. INFORMANT Address <u>Mrs. William Young - RR Beardsboro</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Vascular Renal Failure</u> DUE TO (c) <u>Valvular Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>years</u> <u>years</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) _____					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____									
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>19</u> p. m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I attended the deceased from <u>Nov 11, 1960</u> to <u>April 17, 1962</u> , that I last saw the deceased alive on <u>April 17, 1962</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>4/17/62</u>				
ACTUAL SIGNATURE <u>Valde M. Seim</u> M.D.					PHYSICIAN'S NAME (Type) <u>VALENT M. SEIMON M.D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					22b. DATE THEREOF <u>4-20-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST MARYS</u>		22d. LOCATION (City, town, or county) (State) <u>AQUASCO, MD.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>					ADDRESS _____		24a. REC'D BY REGISTRAR DATE <u>APR 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Caroline S. Kane</u>					

